2012 Retiree Benefit Election Form

ARLINGTON

Complete ALL sections – If not enrolling, select "I Decline". ***IMPORTANT:*** All participants must provide a social security number to enroll. Retirees and/or family members enrolled in a City plan AND eligible for Medicare must complete Section III below and provide a copy of your Medicare card to the City.

I. Personal Information - please print

Effective Date_____

Name_____ ❑ Retiree (RET) ✱❑ Surviving Spouse (Surv Sp)

✱Name and Social Security Number of City Retiree _____

Daytime Phone _____ Cell Phone _____

Mailing Address: _____

Address Changes? ❑ Yes ❑ No E-mail address _____

II. Retiree & dependent Information

Relationship and Plan	Name	Birthdate	*Social Security No.	Action
❍ RETIREE ❍ Medical ❍ Dental ❍ Vision				❍ Add ❍ Change ❍ Drop ❍ No change
❍ SPOUSE ❍ SURVIVING SPOUSE ❍ Medical ❍ Dental ❍ Vision				❍ Add ❍ Change ❍ Drop ❍ No change
❍ DAUGHTER ❍ SON ❍ Medical ❍ Dental ❍ Vision				❍ Add ❍ Change ❍ Drop ❍ No change
❍ DAUGHTER ❍ SON ❍ Medical ❍ Dental ❍ Vision				❍ Add ❍ Change ❍ Drop ❍ No change

*Social Security Number is REQUIRED

III. Medicare Information

Last Name, First Name	Relationship	Eligible Date	Effective Date	Medicare Number	(Y= Yes N = No) Part A	Part B	Part D

IV. METLIFE Dental Place an "X" in the appropriate box below:

Plan	Ret or Surv Sp Only	Ret or Surv Sp & one dependent	Ret or Surv Sp & two or more deps.
DHMO	❍ $9.60	❍ $18.23	❍ $27.34
PPO Low	❍ $13.53	❍ $26.82	❍ $47.21
PPO High	❍ $32.65	❍ $64.65	❍ $113.81

❍ **I decline DENTAL coverage** for: ❍ myself / ❍ my spouse / ❍ my dependent children **DUE TO:** ❍ Existence of other coverage / ❍ Don't want/need

V. EYEMED Vision Place an "X" in the appropriate box below:

Plan	Ret or Surv Sp Only	Ret or Surv Sp & one dependent	Ret or Surv Sp & two or more deps.
Vision Plan	❍ $4.72	❍ $9.90	❍ $15.09

❍ **I decline VISION coverage** for: ❍ myself / ❍ my spouse / ❍ my dependent children **DUE TO:** ❍ Existence of other coverage / ❍ Don't want/need

For office use only: Rev. 9/11

Lawson #	_____	Medical	_____	R x 65	_____
Eff Date	_____	Dental	_____	Term File	_____
Documentation	_____	Vision	_____	Lawson	_____
Coupon Book	_____	Med 65	_____	Finance	_____

Retiree Medical / Pharmacy Plan Options

REMINDER: The City contribution toward medical coverage is based on the year of your retirement.

Year of Retirement_____

❑ Retirement before 2008: **Select your Years of Service:** ❍ 10-14 ❍ 15-19 ❍ 20-24 ❍ 25-29 ❍ 30 and over

❑ Retirement after 2007: **Enter your Years of Service:** 10, 11, 12, 13, …, 30 & Over _____

VI. Under Age 65 Plan Enrollment - UnitedHealthcare Medical & Pharmacy (Rx)

Plan	Select Coverage Level		Enter Your Monthly Cost
❍ Value Medical & Rx	❑ RET only	❑ Spouse only (RET 65+)	
❍ Core Medical & Rx	❑ RET + Spouse	❑ Surv Sp only	$_____
❍ Plus Medical & Rx	❑ RET + Child or Children	❑ Surv Sp + Child or Children	Refer to 2012 Monthly Rate Chart
	❑ RET + Family		at www.arlingtontx.gov

❍ **I decline MEDICAL and Rx coverage** for: ❍ myself / ❍ my spouse / ❍ my dependent children
DUE TO: ❍ Existence of other coverage / ❍ Don't want/need

VII. Age 65+ Plan Enrollment - UHC Medicare Advantage HMO or AARP Supplement Plan

Note: Both UHC Medicare Advantage HMO and AARP require you complete their form and mail it to them to enroll. To change or drop coverage you are required to complete a City form AND personally notify AARP / UHC Medicare Advantage HMO regarding your change in enrollment decisions. The City is not authorized to enroll, change, or drop coverage in these plans for you. You will be responsible for 100% of all billings for plans you enroll in if you do not notify both the City and UHC Medicare Advantage HMO and/or AARP of your enrollment change.

Plan	Select Coverage Level		Enter Your Monthly Cost
❍ UHC Medicare Advantage HMO with Rx	❑ RET only	❑ Spouse only (RET <65)	$_____
❍ AARP K Supplement	❑ RET + Spouse	❑ Surv Sp only	Refer to 2012 Monthly Rate Chart
❍ AARP F Supplement			at www.arlingtontx.gov

❍ **I decline MEDICAL coverage** for: ❍ myself / ❍ my spouse
DUE TO: ❍ Existence of other coverage / ❍ Don't want/need

VIII. Age 65+ Pharmacy Plan Enrollment - UHC Medicare Part D Rx Plan

Plan	Coverage Level	Years of Service	Your Monthly Cost
❍ UHC Medicare Part D	_____	_____	_____

Note: If at any time you are eligible for Medicare Part D and you decline this coverage, you are required to complete a UnitedHealth Rx Part D – Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage form and return to Workforce Services, P.O. Box 90231 MS 63-0790, Arlington, TX 76004-3231 along with this Retiree Insurance Election Form.

❍ **I decline PART D PHARMACY coverage** for: ❍ myself / ❍ my spouse **DUE TO:** ❍ Existence of other coverage / ❍ Don't want/need

IX. Monthly Cost Payable to City of Arlington Insurance

Enter the cost of each plan you have enrolled here:

$_____	+ $_____	+ $_____	+ $_____	+ $_____	= $_____
Dental	Vision	Under 65 Medical	UHC Medicare Advantage HMO or AARP Plan (65+ Plans)	UHC Part D Rx (65+ Plan)	Total Payment Due to City Monthly

X. Mailing Address

Enrollment/Change Form:
City of Arlington
Benefits - MS 63-0790
PO Box 90231
Arlington, TX 76004-3231

Monthly Payments:
City of Arlington
Finance Dept. - MS 63-0820
PO Box 90231
Arlington, TX 76004-3231

XI. Signatures

_____ _____

RET or Surv Sp Date Workforce Services Date

NOTE: Failure to complete decline statement may disqualify you for 31 day Special Enrollment Rights (please check all applicable items).